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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. *2013-783*

12 **CATHLEEN MARGARET OTT,**
13 **aka CATHLEEN M. SPOTTS,**
aka CATHLEEN MARGARET SPOTTSOTT,
14 **aka CATHLEEN MARGARET SPOTTS**
P. O. Box 692651
Stockton, CA 95269

A C C U S A T I O N

15 **Registered Nurse License No. 206391**

16 Respondent.

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18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing ("Board"),
22 Department of Consumer Affairs.

23 2. On or about March 31, 1970, the Board issued Registered Nurse License Number
24 206391 to Cathleen Margaret Ott, also known as Cathleen M. Spotts, Cathleen Margaret
25 Spottstott, and Cathleen Margaret Spotts ("Respondent"). Respondent's registered nurse license
26 expired on March 31, 2012.

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1 the nurse knew, or should have known, could have jeopardized the client's health or
2 life.

3 8. Regulation 1443 states:

4 As used in Section 2761 of the code, "incompetence" means the lack of
5 possession of or the failure to exercise that degree of learning, skill, care and
6 experience ordinarily possessed and exercised by a competent registered nurse as
7 described in Section 1443.5.

8 COST RECOVERY

9 9. Code section 125.3 provides, in pertinent part, that the Board may request the
10 administrative law judge to direct a licentiate found to have committed a violation or violations of
11 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
12 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being
13 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
14 included in a stipulated settlement.

15 FIRST CAUSE FOR DISCIPLINE

16 (Gross Negligence)

17 10. In and between 2007 and July 2009, Respondent was employed as a registered nurse
18 for Maxim Healthcare Services, a home healthcare service company located in Stockton,
19 California.

20 11. On or about June 19, 2009, patient H. A., a 15 month old male toddler, was admitted
21 to service with diagnoses including seizures, developmental delay, brain anomaly, age-related
22 developmental needs, secundum atrial septal defect, and gastrostomy status. Various durable
23 medical equipment were maintained in the patient's home, including oxygen tubing, an Ambu
24 bag with face mask (infant), oxygen tanks, and an oxygen concentrator. The patient's functional
25 limitations included 02 SATS, total ADL care, and continuous supplemental oxygen. The
26 patient's initial admission summary stated "client has episodes of desaturation which requires 02
27 at 2-5 LPM via mask". The initial admission orders included the following:

28 SN to administer 2-5 LMP 02 via mask PRN respiratory distress/desaturation.

SN to suction mouth for excess secretions PRN.

SN to monitor for s/s of respiratory distress or desaturation and notify MD each event.

12. On or about July 1, 2009, Respondent was providing care for the patient in his home. The patient went into respiratory distress and stopped breathing. Respondent attempted to perform CPR, then called 911 (the patient's parents were absent at the time of the incident). Respondent admitted to not using an Ambu bag or oxygen. Paramedics arrived within 5 minutes of the emergency call. The paramedics suctioned and "bagged" the patient, then transported him to Lodi Memorial Hospital.

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about July 1, 2009, Respondent was guilty of gross negligence in her care of the patient within the meaning of Regulation 1442, as follows:

a. Respondent failed to follow the guidelines for cardiopulmonary resuscitation in that Respondent failed to place the patient on a firm surface to assure effective chest compressions (Respondent reported that she picked the patient up and put him on the sofa on top of a “Bobby Pillow”, claiming that it was the firmest surface she could find); failed to apply suction; failed to apply the Ambu bag to assist with the patient’s breathing; and failed to apply oxygen.

b. Respondent failed to check all life sustaining equipment in the patient's home at the commencement of her shift to ensure that the equipment was in functional order and available for use as needed for the patient, who had multiple risk factors.

c. Respondent failed to follow the physician's orders when she failed to apply oxygen and failed to suction the patient to maintain airway patency.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

14. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 10 through 12 above.

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about July 1, 2009, Respondent was guilty of incompetence in her care of the patient within the meaning of Regulation 1443, as set forth in paragraph 13 above.

1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Criminal Conviction)**

3 16. Respondent is subject to disciplinary action pursuant to Code section 2761,
4 subdivision (f), in that on or about August 30, 2010, in Calaveras County Superior Court, Case
5 No. 10T17962, Respondent pled guilty to violating Vehicle Code section 20002, subdivision (a)
6 (hit and run, property damage), a misdemeanor, a crime substantially related to the qualifications,
7 functions, and duties of a registered nurse. The circumstances of the crime are as follows: On or
8 about July 17, 2010, Respondent was backing her vehicle in a southerly direction on a private
9 driveway while attending a garage sale. Respondent was backing the vehicle unsafely, causing
10 her left rear tire to leave the paved portion of the driveway. The vehicle slid down a dirt
11 embankment and struck a wooden fence at a nearby residence. A witness at the scene used his
12 vehicle to pull Respondent's vehicle up from its point of rest. The witness told Respondent who
13 owned the fence. Respondent made no effort to provide her personal or insurance information to
14 the property owner, and left the scene in her vehicle.

15 **PRAYER**

16 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
17 and that following the hearing, the Board of Registered Nursing issue a decision:

18 1. Revoking or suspending Registered Nurse License Number 206391, issued to
19 Cathleen Margaret Ott, also known as Cathleen M. Spotts, Cathleen Margaret Spottsott, and
20 Cathleen Margaret Spotts;

21 2. Ordering Cathleen Margaret Ott, also known as Cathleen M. Spotts, Cathleen
22 Margaret Spottsott, and Cathleen Margaret Spotts, to pay the Board of Registered Nursing the
23 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
24 Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: MARCH 18, 2013

for 
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2012106565